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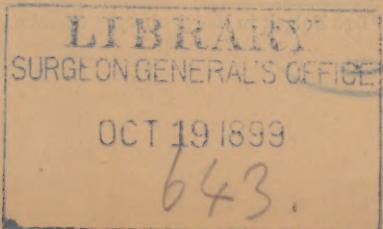
MEMBRANOUS DYSMENORRHEA FROM REPELLED ERUPTIONS.

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Not the least curious and wonderful of all the physiological processes known to us is the periodical development of the lining membrane of the uterus. This process of "nidation," or nest-making, is as essential a factor in menstruation as it is in generation. If it occurred only once in a year, as in the estruation of animals, it would still be remarkable for its delicacy, and for the peculiar contingencies with which it is beset. But, in women, its monthly repetition multiplies the risks of its becoming disordered, and there are comparatively few who pass through the whole period of menstrual life without suffering some of these consequences.

Membranous dysmenorrhœa is not so well understood, nor so skilfully and successfully treated as other kinds of painful menstruation. This fact is partly due to its relative infrequency. For, compared with the spasmodic and obstructive varieties it bears about the same proportion that cases of breech presentation do to those of the cephalic extremity.

Now that the shreds, or casts, thrown off in this disease are known to be caused by the exfoliation of hypertrophied mucous membrane of the uterus, and not by the exudation of lymph, and the formation of a new or croupal membrane, its morbid anatomy is very much simplified. And the fact that this product is decidual and not diphtheritic, homologous and not heterologous, is destined greatly to modify its special therapeutics.



But, however great the advance that has already been made, the etiology of membranous dysmenorrhœa is incomplete. For, although the felt-like shreds, or strips, which are moulted in this disease are recognized as portions of a menstrual, or nidal decidua, it still seems practically impossible for physicians to separate in their minds the formation of this product from the existence of the inflammatory process. The most recent author even proposes to style it an epithelial endometritis (*endometritis exfoliativa*).^{*} On the one hand he declares that the sieve-like casts and pieces, consist of the hypertrophied mucous membrane which, from the rapid production of free cells, is detached and thrown off at stated periods; on the other that the process is inflammatory and exudative, and not a mere exfoliation. Experience proves, however, that while a woman with membranous dysmenorrhœa may also have endometritis, she is quite as likely to have ovaritis, or even endocarditis as a coincident affection.

Accepting the view of Oldham and others that the cause of this disease may frequently be found in ovarian irritation and inflammation; the idea of Dewees that the rheumatic diathesis is responsible for its existence in a certain proportion of cases; and the more modern claim that it may be caused by uterine deviations, my experience leads me to conclude that there are some examples of this affection which are inexplicable and incurable by, or through, either or all of these different theories. In other words, these theories do not apply to all cases indiscriminately.

The most intractable cases of this singular affection that have come to my knowledge have been associated in their clinical history with the existence and sudden disappearance of a cutaneous eruption. This eruption may, indeed, have been very slight and possibly have been forgotten by the patient herself. It may also vary in its character in different persons, being either papular, herpetic or vesicular, squamous, syphilitic, or erysipelatous. In one of my cases it was a "rash, like prickly heat;" in another, the patient was positive that she had once had the "hives," and that her menstrual difficulty followed directly upon their being "driven in."

*Dr. Beigel, in the *Archiv. fur Gynakol.*, Band ix. Heft I.

Sometimes the appearance of this eruption upon the face, hands, or body, alternates with the menstrual disorder ; but more frequently, unless medicines have been taken to "drive it out," no trace of it can be found at any time. In one case of erysipelas of the legs and thighs the lesion extended to the genitals, and to the womb, and a membranous dysmenorrhœa of six years standing was the direct result.

In one of my patients, who was very ill with this form of dysmenorrhœa, the repercussed eruption had not been seen for eighteen years until it blossomed out as the result of my treatment ; and I have recently cured another in whose case the "salt rheum" had disappeared twelve years before, with the immediate advent of shreds and bits of membrane in the monthly discharge.

The comparative frequency of cases of this kind, which have been more or less intimately associated with skin affections, precludes the possibility of their accidental relation. For, out of twelve cases of real membranous dysmenorrhœa which I have treated within the last five years, eight of them have been of this sort. In this list I do not include those milder cases which are very much more numerous, and in which there is merely an increased desquamation of the uterine epithelium in the form of diaphanous shreds, or patches. This contingent of menstruation is sometimes met with in uterine deviations, catarrhal endometritis and menorrhagia, and is much more easily cured.

Sterility is as common and constant a symptom of membranous dysmenorrhœa as is the shedding of the membrane itself. And there can be no better guarantee of the cure of a case of this form of dysmenorrhœa than is furnished by a fruitful conception and labor at term. The clinical history of barrenness often includes the history of old skin affections which, in some unaccountable way, have interfered with the function of reproduction. The remarkable effects of certain mineral waters as a cure for sterility, and for complicated disorders of the catamenial function, can best be explained by their value in some chronic cutaneous diseases which have first been repelled and then resisted other modes of treatment.

Anatomically the epithelium is the epidermis of the mucous

membrane. Clinical experience has long since demonstrated the mutual sympathy and morbid relations of these two surfaces. The occurrence of a metastasis of disease from one to the other is in no wise rare or remarkable. Indeed it is very common, more especially in case of those membranes which, like the lining of the nose, of the throat, and of the utero-vaginal tract, are in direct continuity with the external integument.

The modern classification and description of skin affections is quite in accord with the idea that, under certain circumstances, almost any of them might be translated to the uterine mucous membrane. The moment we define eczema as "a catarrhal inflammation of the skin,"* we have declared upon its proneness to migrate from the outer to the inner surfaces of the body, and to work mischief in them.

Manifestly, the internal lesion, which is due to this cause, will be intractable, if not grave in character, in ratio with the delicacy of the function involved. For the monthly formation, enlargement, separation and reproduction of the uterine mucous membrane, its progressive changes, its retrogressive or fatty degeneration, and the escape and cessation of the flow are so many physiological steps that such an invasion would almost certainly interrupt or modify. And it might very easily change the natural and proper exfoliation of the uterine epithelium at the month into a morbid separation of the subjacent mucous layers, and the shedding of a thick and tough cast of the uterine cavity.

That these identical consequences do sometimes follow the repercussion of an eruption, I am fully persuaded, not only because I have been able to trace the beginning of a membranous dysmenorrhœa directly to such an accident, but also because I have found it possible to cure this secondary form of the disease through a knowledge of this fact, and by using it as a key to the special therapeutics of the case.

Since the preparation of this paper was begun, two of my colleagues have consulted me concerning the best treatment

* *A Handbook on the Theory and Practice of Medicine*, by F. T. Robert, M. D., etc., p. 1018.

for membranous dysmenorrhœa, each of them having a case of the kind under his professional care. The above theory of its exceptional origin was explained, and they were asked to inquire particularly with reference to the clinical history of a previous or coincident skin affection. The following evidence afterward supplied by these gentlemen, has the merit of being fresh without having been fabricated expressly to support the theory under consideration.

Case 1.—This case is reported by Prof. G. A. Hall, M. D., whose notes read as follows: “Mrs. M., aged 35 years, resides in Chicago. The menses first appeared at 13 years of age, and were natural until her marriage, at twenty-two. She has two children, the first of which was born ten months after marriage, and the other three years later, with one abortion since that time.

“During her youth and up to the period of her first labor, she was troubled with the ‘hives,’ or nettle-rash, but after the birth of the child it ceased, and she had nursing sore-mouth for weeks. This was followed by a chronic diarrhoea, which lasted for several months. The tongue has remained soft, patulous, spongy, and is sometimes slightly ulcerated.

“After the diarrhoea was controlled, a small, round spot, as big as a half-dollar, would appear on the inside of the left thigh. It came first before, and remained during the menstrual flow. It looked very red, and was attended with an intolerable itching, but it disappeared nearly three years ago, at the time of the miscarriage. The latter was not painful, but after a moderate flowing for twenty-four hours, the embryo and placenta were thrown off intact. Ten days later she had secondary haemorrhage which lasted for ten weeks. She was greatly reduced in strength, and has never fully recovered her health.

“Four weeks after the cessation of that flow the menses were resumed, and for the first time the membranous shreds and casts, of which I send you a specimen, appeared. Her appetite became morbid, and she craves starch and salt. Since the miscarriage she has never had the itching spot on the inside of the thigh, or anywhere else externally. The catamenia are

now attended with moderate pain and flowing for three days, when the membrane is extruded, after which the pain ceases, and the flow continues for three days longer, but moderately."

Case 2.—For the details of this case I am indebted to J. E. Morrison, M. D., of Hyde Park, Illinois. "Miss G. M., twenty-three years of age, began to menstruate in her twelfth year. From her second year until puberty she had suffered from running sores, and occasionally from an eruption like bee-stings, with a fine rash over the body, but especially about the waist. For the first three years, or until she was fifteen, her skin was never well, nor was the menstruation either painful or too profuse.

"About this time, however, the eruption would sometimes disappear from the external surface, and this change was always observed to increase the monthly pain. For the last four years, excepting only at very long intervals and temporarily, no sign of the skin affection has shown itself; but the dysmenorrhœa has become more and more pronounced. Within that time it has assumed the membranous form, and firmly organized shreds are thrown off at every return of the 'period.' Her suffering in that interval has been very severe, and thus far has resisted all medical aid."

Concerning the curative indications which are deducible from this bit of clinical experience, we have to acknowledge that as yet they are neither very explicit nor complete. To have treated only eight cases of this particular kind of membranous dysmenorrhœa, and to have been consulted in perhaps a dozen others by letter and otherwise, does not warrant us in dogmatizing upon its special therapeutics. The temptation to speculate upon this subject, however, is very strong, but we forbear. For what a remedy "ought" to do, and what it really will do, are not always the same thing.

Where the precise character of the eruption which has preceded the menstrual lesion is unknown, we can not, perhaps, do better than to begin the treatment with the use of Sulphur. In the case already referred to,* where the eruption had not

* *Vide* the author's *Clinical and Didactic Lectures on the Diseases of Women*, 1872, p. 195.

been seen for eighteen years, this remedy, in the thirtieth dilution, had the desired effect, and produced a marked and lasting amelioration in the uterine symptoms.

But, if the nature of the eruption can be determined, either by direct inspection, when it crops out occasionally; through the description of an intelligent parent or patient, who remembers just what it was; or, by the ferreting action of Sulphur, we shall know better how to proceed. In this case we venture to recommend the following practical hints for trial and confirmation, or rejection, as they shall prove worthy or otherwise:

If the eruption is, or has been, like Urticaria, give Arsenicum alb., Rhus tox., or Urtica urens.

If what is vulgarly called the "hives," Apis mel. (in the third decimal trituration), Belladonna, Chamomilla.

If it is, or was, herpetic or vesicular, Cantharis, Rhus tox.

If squamous, or "scurfy," Borax,* Arsenicum, Nux mosch., Dulcamara, Silicea, Sepia.

If scrofulous, and otherwise unclassifiable, Sulphur, Calc. carb., Hepar sulph., Mercurius.

If syphilitic, Thuja, Nitric acid, Mercur. iod., Kali iod., Mezereum.

If from suppressed rubeola, or if it alternates with ophthalmia, Pulsatilla; or, in the former case especially, Cuprum acet.

If it is erysipelatous, Belladonna, Cantharis, Rhus tox., Apis mel.

Should further experience verify the importance of knowing that repelled eruptions do sometimes cause a membranous dysmenorrhœa, this limited and imperfect list of remedies will doubtless be very much changed and enlarged. It is not improbable that there are some medicines which, although they are not now supposed to possess any curative relation to the disease in question, may yet prove, through this general indication, to be very useful in its treatment.

* *Transactions of the Homœopathic Medical Society of the State of New York*, Vol. X., p. 280.

There are undoubtedly good grounds for confidence in the virtues of the Calcarea carb. as a remedy in this particular variety of dysmenorrhœa. It does not appear to be suited to all cases, and certainly does not deserve to be extolled as a specific; but, when it is appropriate, its curative action is quite as marked as it often is in too frequent menstruation and in menorrhagia. I have no question that, as a uterine polychrest, it is possessed of an intimate and specific relation to the fatty changes which occur each month in the uterine epithelium, the physiological separation of which permits and provides for the exit of the menstrual blood from the surcharged capillaries. We have a forcible illustration of this quality of the Calcarea, in its ability to discuss certain morbid growths, which it resolves away through a similar metamorphosis; but more crudely, in the power of lime to detach the pseudo-membrane in croup and diphtheria. Our workers in the *Materia Medica*, and in gynaecology, should define this relation, and develop this suggestion.

The frequent indication for Calcarea carb. in scrofulous and other skin affections is suggestive of its value in the membranous dysmenorrhœa, which is secondary upon these eruptions. With the few exceptions in which I have prescribed the sixth or the twelfth attenuation, I have always given the third decimal trituration in these cases.

If we find, in a given example, that dysmenorrhœa due to this cause is complicated with ovaritis, or rheumatism, the prescription may need to be modified. But it should not be forgotten that ovaritis itself is as likely to result from certain suppressed eruptions as it is from the sudden metastasis of a gonorrhœal inflammation.

In a certain ratio of cases, the best-chosen remedy that is prescribed on these, or similar indications, will fail to complete the cure without manual assistance of some kind. This is more especially true of the treatment of membranous dysmenorrhœa when it coexists with retroflexion (not retroversion) of the womb. Under these circumstances the reposition of the organ, as a condition for the prompt and ready exit of the flow; allays and averts the tendency to a moulting of its nidal

membrane. And the effect of this expedient is still more decided if a free dilatation of the cervical canal is also secured at the mouth.

It is possible that this disease may arise as a sequel to diphtheria, when it would require to be treated accordingly. But the off-hand method of prescribing for it as though it were always and strictly a pseudo-membranous affection, is not only unsatisfactory in theory, but unsuccessful in practice.

